1952

A study of twelve unmarried mothers admitted to Quincy City Hospital between April, 1948 and February, 1951.

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK.

A STUDY
OF TWELVE UNMARRIED MOTHERS
ADMITTED TO
QUINCY CITY HOSPITAL
BETWEEN
April, 1948 and February, 1951

A Thesis

Submitted by

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I

INTRODUCTION

Purpose and Scope.

This is a study of twelve unmarried mothers known to medical social service at Quincy City Hospital from April, 1948 through February, 1951 to determine the nature of their plans.

It is felt that such a topic would be of interest because the writer noted at this hospital the importance of help given these mothers who were referred to social service following delivery of their babies.

It is hoped that this study will bring forth some understanding of these mothers and will show how the worker participated in their planning.

For purposes of the investigation the following general questions were posed:

1.--What was the significance of plans made by these mothers?

2.--In what areas of assistance was casework help requested?

3.--How did the worker help with the various problems,

The term patient was often used by the writer referring to unmarried mothers because it is customary procedure at QCH for any person hospitalized or receiving clinical care.

In Chapter II, a description of Quincy City Hospital is given so that the reader might have a clearer picture of the

background of this study. In the following chapter a review of some literature, which discussed the unmarried mother and casework with her is presented. In Chapter IV, case studies and analyses are given. The final chapter contains a summary and conclusions of the thesis.

Sources of Data.

The record files of the medical social service department at Quincy City Hospital were utilized for the sources of information of this study. The records contained both medical and social data as well as other information given on social service "blue" sheets and correspondence with the patients and other agencies. Only those records which had been completed and designated as case closed were used.

Method of Procedure.

Twenty-four patients were referred to medical social service because of birth of illegitimate babies during the period of the study - twenty case records and four limited service cases.

In order to determine unmarried mothers in the strict sense of the word i.e. without previous marriage, and so as to give uniformity and focus to the problem under study, the following cases were excluded:

1. All four limited services because of insufficient evidence for the investigation.
2. Three cases with the major casework done by other agencies.

3. Two cases of patients formerly married.
4. One case of stillbirth.
5. One case in which two separate illegitimacies were involved and which would complicate the study.
6. One case in which placement of the baby for medical care was necessitated by the urgency of its critical condition with little hope for recovery.

Twelve cases remained as the basis of this thesis. The writer abstracted material from these cases according to the schedule in the appendix. There was no attempt made to compile a statistical study. Conclusions were derived only from a specific group and related to the problem under investigation.

Limitations of the Study.

One limitation was the fact that in most cases the baby's father could not be reached for comment so that an estimate of his feelings was usually that as given by the patient.

The writer also recognized his own limitations and possible errors of judgment.

For purposes of the study the influencing factors in the patients' plans were limited to their immediate situations. Furthermore, with most casework contacts ending when the patients left the hospital, the writer could not properly ascertain the success or failure of plans.

II

QUINCY CITY HOSPITAL

1

A Short History of the Hospital

Quincy City Hospital came about as the result of the efforts of Dr. John A. Gordon who wanted to do something to alleviate the suffering from inhalation among the granite workers.

A charter was granted by the state legislature on March 13, 1889 and a corporation was organized. The hospital was dedicated on June 17, 1890. One hundred and two patients were admitted the first year. In 1892, the training school for nurses was begun.

For thirty years following its founding, Quincy City Hospital was supported by the generosity and devotion of public spirited citizens but the overwhelming demands, too great for private benefaction, brought city control of the hospital on March 1, 1919 and a change from a voluntary to a tax-supported hospital.

A general medical service building was opened in 1924; the Hunting Building in 1925 with eighty-one beds; and the medical and surgical building in 1929 with one hundred and

three beds. From two small wooden buildings connected by a corridor, the hospital in 1935 had twelve buildings where approximately three hundred and seventy-five patients could be treated.[1]

2

Treatment Facilities

The Quincy City Hospital is a modern, well-staffed, tax-supported, acute, general hospital serving the medical needs of Quincy. However, patients may be admitted from out of town, if they have a member of the hospital staff as their private doctor. Non-residents are charged a higher rate than people of Quincy, who may have free medical care, if unable to pay. All patients must be referred by a doctor. Present accommodations are between three hundred, twenty-five and three hundred, thirty-five beds and sixty bassinets.

Quincy City Hospital offers the usual services of a large metropolitan hospital. There are close to five hundred personnel at the hospital, most of whom are under civil service.

3

The Medical Social Service Department

The medical social service department was introduced to

1. Dr. Joseph P. Leone, "History of Quincy City Hospital", "DIVIDENDS", December, 1935, p.1.

the hospital in March, 1925 and eighty-one cases were reported during the first year. The present medical social service department consists of a director and a medical social worker, both qualified professional personnel, and one department secretary. There are also facilities each school year for the supervised training of one medical social work student.

Medical social service coverage is handled by the director of the department and the other medical social worker. Referrals are usually made by doctors and nurses but they may also come from other hospital personnel or outside agencies. The same holds true in respect to referrals of unmarried mothers.

There are several functions of the medical social worker at Quincy City Hospital. The primary function is casework which is carried on in collaboration with the medical team, especially the doctor. Help is given around the social implications of an illness and continues as long as the medical condition exists or the situation is referred to another agency for further assistance. In referrals, the interpretation of the medical social problems is a very important function of the worker.

Members of the medical social service staff, along with the rest of the hospital team, also participate in the development of problems within the hospital, give instruction to pro-

fessional personnel such as nurses, help in the development of social and health programs in the community, and carry on medical social research if the need exists. Through such varied activities, the medical social worker is able to increase his knowledge of the situations, needs, and interests of the patient as they are related to his illness.

III

DISCUSSION OF THE UNMARRIED MOTHER AS NOTED IN THE LITERATURE

1

Description of the Unmarried Mother

In describing the unmarried mother, Queen and Mann[1] point out that various studies have indicated that these women are, for the most part, between eighteen and twenty-four years of age with a large number under sixteen. The majority are native born Americans of the white race but the proportion among Negroes is greater. They seem to be evenly distributed among various religious groups, have little formal education as a rule, and are found more in the city than in the country.

Continuing the description, most unmarried mothers are basically of good character and normal mentality but many come from broken homes or bad environment or leave home under fourteen years of age with little chance for proper social adjustment. Their occupations are usually low-paying and monotonous. They are most often found among domestic servants, factory workers, waitresses, store clerks, and students.

The above social factors seem significant in general but no one factor of combination of these factors can prove the

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1. Stuart A. Queen and Delbert M. Mann, Social Pathology, p.160-161.

reason for these women's illegitimacy "since the whole life pattern of the individual beginning at birth is important."[2]

Morlock[3] states that these women usually come to an agency or hospital feeling shock, fear, and rejection. To them, the world seems to care little for their predicament. They are lost, bewildered, and in search of a way out. Generally, they appear not ready to meet the reality of having a baby. Often, internal pressure of guilt and anxiety are increased by actual or expected censure of friends and relatives. Standing alone, they do not dare to trust themselves or those ready to offer assistance.

The married mother looks forward to the fulfillment of her role as a mother. She is usually surrounded by the love and affection of her husband, as well as her relatives, and bears the baby with a happy outlook. The unmarried mother, however, is preoccupied with the need to decide whether to keep the baby or not. Either decision will exact an emotional penalty and involve sacrifice.

If the unmarried mother keeps her baby, she must often plan for its care and support alone, as she may be rejected and deserted by the putative father. Many times she is ashamed or afraid to let her family know of her condition, or her family

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2. Percy G. Kammerer, A Study of Five Hundred Cases of Unmarried Mothers, Introduction, p.2.

3. Maud Morlock, "Shall I Keep My Baby"? U.S. Children's Bureau, July, 1942, p.1.

is emphatic in its rejection of her. Shame, expecting condemnation, loneliness, panic, loss of status, and need for help in practical planning often prevent the unmarried mother from fulfilling her role as a mother.[4]

The final answer may lie in the psychological structure of the unmarried mother who, for the most part, is a neurotic individual; illegitimate pregnancy appears to be a symptom of an underlying problem.[5]

2

Changing Attitudes Toward Unmarried Mothers

Historically and conventionally the term "illegitimate" formerly applied to the child of an unmarried woman. Furthermore, "polite" society previously ignored the putative father and his part in the whole affair. Society condemned the mother, stigmatized the child, and forgot the father.[6]

The first real step in this problem occurred in 1922 when the American Bar Association adopted a proposed Uniform Law. This law stated that "the parents of a child born out of wedlock and not legitimatized owed the child necessary maintenance, education, and support. The alleged father was liable to pay the expenses of the child's funeral, if it died, and the cost of the mother's pregnancy and confinement. The mother could also

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4. Babette Block, "The Unmarried Mother," U.S. Children's Bureau, July, 1951, p.1.
5. Ibid., p.1.
6. Grace Abbott, The Child and the State, p.513.

recover from the father of the child a reasonable share of necessary support for the child through legal representation. Failure of the father to support when paternity was established, could be punished legally.[7]

Russell[8] comments that those institutions and agencies first organized to render service to these women, were influenced and motivated by two distinct policies: the first, moral rehabilitation and the second, protection of these women since they wished to conceal their maternity. Emotional rather than rational attitudes often prevailed, with secrecy being the most important part of the treatment. These situations were considered so shameful and would be so cruelly punished by the community, that no consideration was given to the health of the child, the rights of the unmarried mother or her parents or the child's father.

Russell further states that the community's attitude has been modified in recent years and the primary motive is now the protection of the child and the development and social adjustment of the mother. Institutions and agencies now assist the mother in adjusting herself to the community and assume that the child's relatives have a responsibility for its welfare.

This change in emphasis had several causes. First, the community became aware of the higher rate of infant mortality

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7. Ibid., p.501.
8. Marian E. Russell, "Responsibility of the Hospital to the Unmarried Mother and Her Child", HOSPITALS, August, 1938, p.1.

among illegitimate children. The publication of facts regarding certain types of commercial agencies, aroused public opinion as to the responsibility of safeguarding the unmarried mother. It was also demonstrated in certain areas that by social casework, through individualized treatment, satisfactory results could be attained in the placing of responsibility for the child's care in in the rehabilitation of the mother.[9]

Under several programs operated by the U.S. Children's Bureau, many health and social services are to-day made available to these women and their children. The unmarried mother who wishes to keep her child and has the understanding and support of her family and community, would seem to present no particular problem, since she would return home to assume direct care of the child. Several authors stress the importance of keeping the mother and child together, if possible, so that ties of affection may be established, resulting in the mother keeping the child permanently.

3

Methods of Social Service Assistance

Hollis[10] states that the degree of effective casework assistance to unmarried mothers depends on such determinants as practical arrangements for mother and child; help to mothers in

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9. Ibid., p.1.
10. Florence Hollis, Social Casework in Practice, p.126.

thinking through important decisions; acceptance between the worker, mother, and other interested parties; the handling of emotional pressures; and certain intangible values such as support coming to the mothers from their relationship with the worker.

According to Haynam, there are several casework approaches which the hospital and other social workers can use in working with these women. She feels that the worker should begin where the unmarried mother is, with problems which she describes as most disturbing and needing attention. She should be approached as a total human being, whose incapacity to meet her life situation in part or in whole, makes her dependent on others for help. In the first interview, harm may be done by shutting out the mother as a person and thus increasing her resistance to help. The worker should relieve anxiety and open the way to a meaningful participation between herself and the unmarried mother.[11]

Information should not be of primary importance but rather the mother's expression of her present difficulties. She should be allowed to talk out her feelings in a natural way to relieve guilt and tensions, and thus be more comfortable and free to act in her own realistic planning.

If, at the outset, the worker can relieve anxiety by easing discomforts of external environment, such as help with plans for

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11. Marguerite M. Haynam, Casework Treatment of the Unmarried Mother, p.1.

living arrangements, medical care and financial assistance, a first and necessary step has been taken in the helping process. By sharing the burden of her real and unreal fears, with an increased understanding of her needs, the mother's confusion begins to clear. She begins to relax and frees herself from tension so as to share in and act on the actual problems which begin to emerge. As the worker's understanding of what the pregnancy means to the mother grows, the groundwork for a relationship is laid.

This relationship deepens and strengthens as contacts continue, as feelings are explored, and as confidence is built. These intangible values determine how the mother will mobilize herself around each new situation and experience, since she will need to make some decision related to her individual psychological patterns and the realities of living. Planning for the child is a major consideration in casework with the mother, but this need not be an end in itself but a way to understand the more basic feelings and needs of these mothers and to help them to understand their essential problems.[12]

12. Ibid., p.1.

IV

CASE SUMMARIES AND EVALUATIONS

In this chapter, the writer presented summaries and evaluations of all twelve cases, selecting those features which were deemed important in answering the questions under study.[1]

The cases were divided into two groups according to those patients who took their babies on discharge and those who requested living arrangements for their babies. A summary of the main findings is given at the end of the chapter. Identifying data were eliminated and the unmarried mother was referred to as patient.[2]

The first group of cases that follow illustrate the activities of the worker with patients who took their babies.

Case 1:

> M., age thirty years, was referred to medical social service by a maternity home, which was willing to accept the patient and her baby for future planning on discharge. The patient had previously been at this home and presently gave birth to a normal child at QCH. Both the patient and her baby were being checked for syphilis. The cough of the patient was also being investigated.
>
> The patient impressed the worker as being friendly, pleasant, and in good control of herself. She said that she did not wish to go to a maternity home. Her immediate plans were to go home with the baby as she would feel "easier", and later return to work.
>
> The patient further stated that she had known the baby's father for fourteen years. He was now thirty-two years old,

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1. Supra, p.1.
2. Supra, p.1.

a divorce, and had a record of drinking, stealing, and failure to support his wife. The patient told him about the pregnancy as soon as she knew and hoped that he would marry her. He said that he could not afford marriage. She did not want to marry him now but expected support for the baby. Court action was being taken.

The patient was the only girl in a family of five children. The family was not living together but they knew about her pregnancy and had been helpful. The mother and the patient lived together in one room and both had always been very attached to each other. The patient had allowed many opportunities for marriage to slip by as she did not wish to leave her mother.

Her mother was a semi-invalid and was receiving Old Age Assistance. Her father had been working but due to arthritis he was trying to get OAA. The patient said that both parents were irritating to each other although her father visited her mother quite often. A brother, who was single, helped support the parents. The patient's mother said that she wanted her to bring the baby home.

The worker informed the patient that there were no findings of syphilis and her chest X-ray was negative. This relieved the patient's mind very much. Community resources were mentioned such as VNA, a well baby clinic, DPW, and a maternity home for further help for the patient and baby following discharge.

After discharge, a home visit was made to interpret the patient's need for readmission due to a post-partum condition. Home accommodations were found to be inadequate. The baby was losing weight and had a cold. An electric burner for cooking facilities was furnished out of social service funds, since the patient's mother expressed such a need. Home visits for the baby were arranged through VNA as the patient desired this.

After the patient's readmission, the worker learned from the patient's mother that a young school girl had been taking care of the baby. The mother had problems with care of the baby but refused VNA help. She did not want the baby placed and felt that she could manage for the patient's baby. On last contact with the patient, she commented that she would stay at home with the baby pending the court hearing.

She realized that going to a maternity home previously would have been sensible. After the hearing she intended to return to work and also place the baby, as she realized her mother could not care for the child. On request for financial help, she was referred to DPW for further assistance.

Evaluation:

The patient's first plans were to take the baby home and return to work as her mother would care for the baby. She went home on discharge but later decided that she would place the baby following the court hearing, because of her mother's inability to take care of the child.

The patient said that she was influenced in her first plans by the support given her by her mother. However, the patient's plans on second discharge were much influenced by the worker's activity in directing her attention to the baby's needs.

Areas in which help was requested by the patient were as follows:-

1. Help for the baby with medical assistance.
2. Material assistance in arranging cooking facilities at home.
3. Financial assistance through community resources.

The patient said she needed no help in arranging living quarters for herself or the baby at time of discharge.

The worker interpreted the medical problems of patient and baby and suggested resources available for assistance since the patient was taking the baby home. An electric burner was fur-

nished for cooking facilities out of social service funds. Suggestions of placement resources for the baby were mentioned. The patient was referred to DPW for financial assistance and in this way some community agency would be in touch with the patient. The worker gave reassurance and strengthening support to the patient throughout the casework contact by interpretation of her problems and by helping her with her planning. Thus, the patient was planning realistically for the baby as well as herself.

Case 2:

D., age eighteen years, was admitted and delivered of a normal baby the same day. Later, a ward nurse referred the situation to medical social service as the patient was unmarried. The general condition of both patient and her baby were considered good.

The patient impressed the worker as being well-poised but her immediate reaction was fear that the baby would be taken away from her. She said that she intended to take the baby home and return to work. Her mother would care for the baby during the day while the patient worked.

In describing her present predicament, the patient stated that she had previously been engaged but the engagement had been broken by her fiance. She was very upset by this at the time and went out with a friend of this man and had intercourse. This was the last time she saw the friend of her fiance and did not know where he lived. He was about twenty-one years old.

The patient further said that she was the oldest of six children, the youngest being fifteen months old. She left school after completing the eighth grade and had done several types of work since that time. Her family was not well off financially. Her father was working but required medical care weekly because of an allergy. Her mother worked nights at QCH. There were two mortgages on the home and living conditions were overcrowded.

The worker found that the family was known to a family service agency and the family church for history of poor management and poor training of the children. The patient's brother had behavior problems and the parents had little understanding of the boy. The father left the family during the war to serve in the Army. This was his second marriage. The stepmother was reportedly not intelligent in the care of the children and managed money poorly.

When the patient became pregnant, she was afraid to tell her parents but when she did, they were "wonderful." The patient's mother told the worker that she was anxious to do what was right. She said that the family knew nothing about the pregnancy and she thought the patient had appendicitis. Both parents were shocked when they first heard about the patient but they now wanted to help. The mother reiterated that the patient wanted to take the baby home and return to work, and the family agreed to this. The mother would try to find the baby's father and talk to him.

The worker told the patient that the baby would not be taken away, as the patient feared. She also arranged a private hospital room at first for the patient to insure the patient's privacy in interviews. The patient's mother was worried about clothing for the baby and a layette was arranged through the VNA. The mother could not understand why the patient had intercourse with a man she saw only once and the worker pointed out some social implications of the broken engagement.

Specific community resources were mentioned to the patient such as a well baby clinic and VNA since the baby would be going home. A maternity home for both patient and baby was also suggested. Both the patient and her mother were reminded of possible further help through FSS, the family's minister, a lawyer, and the worker herself. Referral of the patient was made to VNA for further baby instruction. The mother was referred to FSS and her minister. The worker collaborated with FSS and a maternity home in plans for the patient and her baby.

On last contact with the patient, she was going home with the baby and rest for a month. Her mother would try to contact the baby's father in the meantime. The patient would return to work and the mother would help care for the baby. Later, the patient was married to a Navy man and he was planning to adopt the baby.

Evaluation:

The patient's first plans were to take the baby home and return to work. These were also her plans on discharge.

The patient said she was influenced in her plans by the support given to her by members of her family. However, the patient's plans for herself and the baby were also influenced by the worker's activity.

Areas in which the patient requested help were as follows:

1. Clothing for the baby.

2. Instruction on baby care.

The patient said she needed no help in making living arrangements for herself and the baby.

The worker focused the casework primarily on the baby's needs since the patient was taking the child home. A layette was arranged for the baby through VNA and the patient was referred to that agency for baby instruction. The patient was told of a well baby clinic, a maternity home, FSS, the family's minister, a lawyer, and the worker herself as resources for further help. The worker collaboraged with these various agencies and later the patient's mother was referred to FSS and her minister for advice. In this way some community agency would continue contact with the patient and direct her in further planning for her baby.

Reassurance and a strengthening support were given the patient by interpretation of the medical social implications of the situation and by assuring her that the baby would not be taken away as she feared.

Case 3:

H., age twenty-eight years, was in the QCH Pre-Natal clinic four months prior to the birth of her baby. She was referred to medical social service by an outpatient nurse at that time for social review as the patient was unmarried.

On first contact with the patient at the clinic, she impressed the worker as being pleasant and friendly but not very bright. Her first reaction was that she wanted to keep the baby. She said that a married sister agreed to board the child.

The alleged father was a man of twenty-four years whom the patient met through a cousin two years ago. She saw him daily at that time and later told him about the pregnancy. He was not interested in marriage and the patient contacted a legal aid society for advice and assistance. This man later said that he would pay for confinement of the patient but no further expenses. A court hearing was to be held in four months but in the meantime this man had married another woman.

The patient was one of six children. Her father was dead and her mother lived in a rooming home and worked in a laundry. The family were evicted three months ago and they were all living apart. The patient was presently living with a young married woman whose husband was in the service. The patient told her mother and a married sister about the pregnancy and the sister agreed to board the baby. The patient had also applied to DPW for help.

Plans of the patient to have that married sister take the baby failed, when that sister became pregnant. The patient then decided to live with her mother who was looking for an apartment. Finally she went to stay with another married sister who had three children and was separated from her husband. The patient was receiving help from DPW and keeping house while her sister worked.

The patient was reassured that her baby would not be taken away as she feared. Dental care and financial help were arranged for the patient on request. A doctor also requested that her blood pressure be taken weekly at home. After delivery, the patient returned to live with her married sister and took the baby. Resources of placement and medical followup on the baby were also suggested. On request, the patient was referred for further financial help.

Evaluation:

The patient's first plans were to board the baby with a married sister but when this failed, she was going to live with her mother who was looking for an apartment. Finally, she went to live with another married sister and was keeping house while this woman worked. After delivery, the patient returned with the baby to live with this married sister.

The patient said that she was influenced in her planning by the support given her by her married sister in accepting her and the baby.

Areas in which help was requested by the patient were as follows:

1. Dental care.
2. Financial assistance.

In this case the patient's planning was further complicated by her attempts to find a place to live. However, she requested no help of the worker in living arrangements and said that she would take the baby with her to a married sister's home.

Since the patient was taking the baby, the worker focused the patient's attention on community resources for the baby for

medical followup as well as mentioning placement possibilities. Assurance was given the patient that her baby would not be taken away and she was given support through interpretation of the various situations involved. Dental care and financial assistance were arranged through DPW and the patient's blood pressure was taken by arrangements through VNA. The worker collaborated with agencies involved in the patient's planning and later referred the patient to DPW for further financial help. In this way contact was kept with the patient through a community agency as to her problems and those of the baby.

Case 4:

> C., age nineteen years, was referred to medical social service by a doctor who was interested in adoption of the patient's baby for one of his patients. The patient had just been delivered of a normal baby and both patient and the child were in good condition.
>
> The patient impressed the worker as being friendly and not unduly upset. She wanted to take the baby home but mentioned no further plans for herself. The baby's father age twenty years, was in the Navy. She knew him for five years and they were to be married. While on leave, he had intercourse with the patient but refused to marry her. He suggested an abortion but the patient wanted the baby anyway. A lawyer was working on the situation.
>
> The patient was the oldest of six children, four brothers and one other sister. Her mother was reported easy-going, lenient, and had little insight. Her father was tense and irritable and had a heavy work schedule. He earned sixty dollars a week and the family just managed.
>
> Both parents knew about the patient's pregnancy. Both parents were willing to have her and the baby home. Relatives would help with clothing for the baby. The worker told the patient and her mother of community agencies for help with the

baby such as child placing and adoption agencies as well as a family service agency for help with the patient. A layette was arranged for the baby. On discharge, the patient went home with the baby. There was no further contact with the patient.

Evaluation:

The patient's first plans were to take the baby home but mentioned no other plans for herself. These plans remained the same on discharge.

The patient's mother said that the family wanted the patient home with the baby and the patient was influenced by the support of her family in her plans.

The area in which help was requested by the patient was as follows:

1. Clothing for the baby.

In this case the patient requested no help in living arrangements for herself or the baby. However, material assistance was arranged through VNA by the gift of a layette for the baby. The patient and her mother were given support and reassurance through the interpretation of community resources available for help such as FSS, child placing and adoption agencies. Since the baby was going home with the patient, the worker recommended referral of the patient to FSS, if she wanted further advice. The patient mentioned no problems of her own.

Case 5:

E., age twenty-seven years, gave birth to a normal baby

and was referred to medical social service by a nurse for social review as the patient had a history of several illegitimacies by different men. Both the patient's and the baby's general condition was considered good.

The patient seemed imperturbed and relaxed. She said she had no problems and everything was arranged. She was planning marriage with the baby's father as soon as his divorce became final. The patient continued that she had arranged for this man's brother to take the baby pending marriage. She planned to work part time to help relieve the financial difficulties of the baby's father. She would room out with a girl friend. The worker expressed willingness to help in any way possible.

The baby's father was a man in his thirties. The patient knew him for quite some time. He had two children by marriage and he had to support them. This man told the worker that he worked regularly as a musician and that he planned to marry the patient following his divorce. He thought the patient was going to take the baby to her room.

The patient had two other children placed out, but admitted having only one other child. A doctor reported her to be unreliable and irresponsible. The patient said that she was one of several children. She left home when she was eighteen years old, after a quarrel with her father. He had beaten her and the other children as well as the mother frequently. She worked as a waitress but was very unhappy and lonely but ashamed to return home.

The patient's only concern was adjustment of the hospital bill and the worker arranged to contact the baby's father regarding this. He was told of resources such as FSS and child placing agencies. The patient later requested to see the worker as she was concerned about staying at QCH another day to wait for the baby's discharge. She was assured that this was to plan for the baby. On last contact with the patient, the baby was being taken to the home of the putative father's brother. The patient was going to work and room out.

Evaluation:

First plans of the patient were to return to work, room out, and to place the baby temporarily with the putative father's brother pending marriage. These plans were the same on discharge.

The patient said that she was influenced in her planning by the interest of the baby's father in marriage.

The areas in which help was requested were as follows:-

1. Adjustment of the hospital bill.

2. Contact with the baby's father.

The patient made no request for help in living arrangements for either herself or the baby. The worker had little chance to help the patient in planning for the baby because she said that everything was arranged. However, the pateint was assured of her need to wait for the baby's discharge so that suitable plans might be made.

The worker contacted the baby's father and he made arrangements for payment of the bill through the accounts office. Thus, the worker assured the patient of no need to worry because of this. The baby's father was also assured of resources available for the baby such as child placing agencies and FSS for further counseling since the patient was going to make her own plans for the baby. The worker also collaborated with the accounts office in interpretation of the financial situation.

Case 6:

> L., age seventeen years, was delivered of a baby with a club foot and the patient was referred to medical social service for social review by a nurse as the patient was unmarried. The general condition of both patient and baby were considered good.

The patient said that she was confused and had a lot of thinking to do. She was worried about the baby's club foot but would like to take the child home. The baby's father was a twenty year old man who worked regularly. The patient knew him for a long time but did not tell him of the pregnancy. She wished to marry him and her mother was trying to contact him. They both considered marriage before but the baby's father wanted to wait until he had sufficient funds.

The patient was the only child living at home but she had stepsiblings. Her mother was working at QCH and her stepfather worked for a soap making concern at good wages. The patient left school in the eleventh grade and held many jobs since that time. Her parents were at first shocked by the pregnancy but were fond of her and wanted her to bring the baby home. The patient's mother told the worker that a stepsister of the patient wanted to adopt the baby but neither the parents nor the patient desired this. The mother reiterated that the patient wanted to bring her baby home.

The worker interpreted to the patient and mother that early treatment of the baby would be helpful. Maternity home resources were also suggested. On request, the patient was given a pamphlet on child care. Interpretation was given the patient's mother and patient about crippled children's services and on request arrangements were made with a specialist to treat the child at home. Advantages of marriage were pointed out to the patient as well as FSS for further advice. The patient's mother was assured of confidence in contacts with worker to avoid publicity. Legal advice was suggested when the patient's mother was concerned about support of the baby.

On last contact with the patient, the baby was being treated at home by a specialist and the baby's father was contributing to the child's support. The couple planned to be married when the patient became eighteen years old.

Evaluation:

The first plan of the patient was to take the baby home and have the child treated for its physical disability. She men-

tioned no other plans for herself, but she would like marriage. On discharge, the plans of the patient were the same, but she intended marriage.

The patient's mother said that she and her husband wanted the patient and baby to come home. The patient stated that she was influenced in her planning by the support given her by members of her family. However, the patient's plans were also influenced by arrangements made by the worker for the baby.

Areas in which help was requested by the patient were as follows:

1. Instruction in baby care.
2. Arrangements for medical treatment of the baby.

The patient requested no help in arranging living quarters for herself or the baby and the worker was unable to help in this respect.

The worker gave strengthening support and reassurance to the patient and her mother by relieving their worries about the baby through interpretation of the medical situation and especially by arranging for a specialist to treat the baby at home. The worker gave further support by furnishing the patient with literature on child care. Resources such as a maternity home and crippled children's services were mentioned as well as suggestion of FSS for further counseling with problems since the patient was taking the baby home. Resources for legal

advice were also given the patient's mother since she was worried about support for the baby. In this way the baby's well-being was protected on discharge through community resources.

Case 7:

E., age seventeen years, was delivered of a normal baby and the patient was referred to medical service by a hospital doctor for social review. Both the patient's and the baby's general health were considered good.

The patient was friendly, well-poised, and talked freely. She planned marriage shortly after her discharge from the hospital. She was going to take the baby and live with the sister of the baby's father pending marriage.

The patient spoke of the baby's father with affection. He was a twenty-two year old man whom she had met outside her home two years ago after his discharge from the Army. They saw each other constantly and began having intimate relations four months before the patient became pregnant. She told him of the pregnancy and he suggested she tell her parents and they would get married. She kept putting this off because she feared her parentt's reaction and she told no one except this man.

The baby's father was worried about this postponement and lost weight. He was also discouraged because he was unable to find work. The patient said that he was the youngest of nine children and was pampered. Other agencies reported that this man had no ambition since leaving the Army.

The patient was one of five children, the youngest being a stepbrother two years old. She had two married sisters, and a brother away in the service. Her father died when she was four and her mother remarried four years ago. The patient and mother were very fond of the stepfather. The patient said her early life had been difficult as her family had been poor. She went through the tenth grade but left school to go to work because she wanted clothes and spending money like other children. At the age of fifteen she was doing counterwork.

Both families now knew about the patient's pregnancy and had accepted the situation. The patient told people that she was married and had registered at the hospital under the name of the baby's father. This man's sister was very kind and understanding to her and would accept the baby and her on discharge. This woman was married to a man away in the service and had three children of her own.

The patient was worried about talk in the community and was assured that this would die out and the important thing was the couple's future behavior. The patient felt that the baby's father needed vocational guidance and arrangements were made for further casework with this man through FSS but he made no contact with that agency, as he was working.

On visiting the patient after discharge to remind her of help through FSS, the patient requested assistance with arranging a pre-marital examination for the couple. This was arranged at QCH. It was later reported that the baby's father was under treatment at another hospital for syphilis. When results of the blood tests were negative, the other hospital approved of plans for marriage and recommended further checkups for the patient and the baby's father at the other hospital.

The worker collaborated with a minister regarding marriage plans and with a worker at the other hospital regarding further checkups. Medical interpretation was given the patient about the need for followup on the baby's father and herself. The patient and her mother were assured there would be no need of publicity of the marriage. Further casework with the couple was referred to the other hospital worker.

Evaluation:

The first plan of the patient was to take the baby and live with the sister of the baby's father pending marriage. These were also the patient's plans on discharge.

The patient said that she was influenced in her planning by the support given her by the baby's father in marriage plans.

She was also influenced in these plans by arrangements of the worker regarding the marriage and the medical situation.

Areas in which help was requested were as follows:

1. Vocational guidance for the baby's father.

2. Pre-marital examination for the couple.

The patient had her own living arrangements and no help could be given by the worker in this respect.

The worker collaborated with FSS in trying to get the baby's father to go to that agency for guidance but no contact was made with him as he was working. Pre-marital examinations were arranged for the couple at QCH. When it was found that the baby's father was being treated for syphilis, interpretation of the medical problems and needs of the couple was given the patient. The worker also collaborated with a minister regarding marriage plans and with the other hospital worker regarding medical followup on patient and the baby's father.

Support and reassurance were given the patient and her mother throughout casework contact by interpretation and assurance that there would be no publicity. No contact was made with the baby's father. Although the baby was taken by the patient the main focus of planning for the child seemed to be complicated by the couple's medical situation. However, referral of the patient was made to the other hospital for further casework

services so as to insure help with the patient as to her own problems as well as those of the baby.

The second group of cases that follow described the activities of the worker with those patients who requested living arrangements for their babies.

Case 1:

> T., age eighteen years, was admitted in labor and later gave birth to a normal baby girl. Both the patient's and the baby's general condition were considered good. Later, because the patient seemed emotionally upset and since she was unmarried, a ward nurse referred her to medical social service.
>
> The patient at first seemed confused and emotionally upset. She spoke freely and pleasantly to the worker but was concerned about her situation. Her first plan was to take the baby home and return to work. A married sister, who lived at home, would care for the baby. The patient was expecting to see the baby's father in a few days and was deferring plans until that time.
>
> The baby's father was a twenty-two year old veteran. The patient had met him at a girl friend's home a year ago. She saw him every night at that time and had frequent intercourse. When she found out that she was pregnant, she told him but then said that she was fooling. She had not seen him for the past three months but was very fond of him and wanted marriage. The baby's father had just graduated high school and was now working part time as a taxi driver. He did not live at home due to family difficulties.
>
> Two ministers, who were interested in the patient's situation, furnished the following information:
>
> > The patient was one of eight children and came from a broken home. Two years previously, she had been taken to court on a stubborn child complaint brought by her father. She was sent to W. House where she stayed a year. She returned home about ten months ago.

> The patient's parents were now divorced and her father, who was very dominating with the patient, was now interested in another woman. Her mother was considered suggestible and not very bright. A twenty-seven year old brother was apparently the most mature member of the family. The patient had no contact with the court now and she kept her pregnancy a secret so that her family would not know.

The patient's mother and brother felt that she should be prevented from bringing the baby home. The mother was disturbed by the entire situation and mentioned that her husband wanted the patient put away. One daughter was upset by possible publicity and thought that the baby should be adopted. The patient's brother believed that the married sister, who would care for the baby, was an "immature" person. He also felt that the family would be quarreling, if the patient and her baby came home.

The patient said that her father was bitter toward her but that he had no right to criticize as he was living with another woman. She considered her father to be difficult and opinionated; her mother could be persuaded to any viewpoint. She believed her present situation would not have occurred if her family life had been less difficult. She was only fond of one member of the family - the married sister who would take care of the baby.

The two ministers were quite active in helping the patient with plans for marriage and in arranging financial assistance for boarding care of the baby. Through their efforts the baby's father visited the patient at a time when she was uncertain and confused.

The worker gave support and reassurance to the patient during the trying period of her planning with problems of housing, finances, marriage, the baby, and family reactions. Contacts were made with members of the patient's family suggesting that they stand by the patient in her difficulties. Advice was given both the putative father and the patient regarding community resources such as a maternity home for the patient and baby as well as counseling for the couple through a family service agency. The patient was given a layette, on request, from social service funds. The putative father was reminded of financial benefits under the G.I. Bill for his intended schooling. Finally, the couple were referred to a maternity home for further counseling and planning for the baby.

On last contact with the couple, they were to be married out of state to avoid publicity. They were going to place the baby for three months pending the solution of housing and financial difficulties. They were both working, were visitng the baby regularly, and were paying for its care. The patient's family were pleased at the prospects of marriage. The baby's father also planned to tell his mother of the marriage and the baby. The patient mentioned how helpful it had been to talk with the QCH worker.

Evaluation:

The patient at first said that she would take the baby home and return to work. Her married sister would care for the baby. However, the patient wanted to defer plans until she had seen the baby's father.

After the putative father's visit and interest in marriage, the patient said that she was influenced in planning by the support given by this man. On discharge she was making plans for marriage, to return to work to help the baby's father, and to place the baby temporarily pending the solution of their difficulties. The couple's planning as well as that of the baby were also influenced by the arrangements made by the worker and ministers.

Areas in which help was requested by the patient were as follows:

1. Contact with the patient's mother.
2. Clothing for the baby.
3. Assistance to the patient and the baby's father with problems of housing, marriage, finances, and the baby.
4. Temporary placement of the baby.

The patient requested no help in living arrangements for herself but did want the baby placed temporarily.

The caseworker spoke to the patient, members of her family, the ministers, and the baby's father, interpreting the various problems. A layette was furnished the baby from social service funds. The worker collaborated with the ministers regarding financial problems and marriage arrangements. Since the baby was being referred for temporary placement, the couple were also referred to the same agency for counseling with their problems as they would affect plans for the baby. Strengthening support was given the couple through help in planning and interpretation of the various situations. They were also assured of agencies ready to help. The patient's family were also given interpretation of social implications and asked to stand by the patient in the trying period of her planning.

Case 2.

> D., age twenty-two years, was delivered of a normal baby and the patient's home doctor made referral to medical social service for help in arranging adoption of the baby. The general condition of patient and baby were good.
>
> The patient said that she would like to have the baby with her but felt that this was not possible. She would return to work in a month. She would not consider going to a maternity home, but planned to live with a married sister also at QCH for delivery at this time. The patient wished to contact a child placing agency.
>
> The patient was controlled and rather reserved. She said the baby's father, age twenty-two years, was a gas station

attendant whom she knew for the past two years. There was no question of marriage. The patient's sister told the worker that this man was at first upset and wanted to help the patient but he later said he had too many financial difficulties. An attorney was working for the patient.

The patient said she had an older brother and sister, both married. Her parents were separated and her mother lived in a rooming home and worked. The patient had discussed her situation with her family and they felt adoption was best. Her married sister was sympathetic and devoted to the patient.

The worker suggested maternity homes for patient and baby and placement agencies. The patient did not wish to go to a maternity home. Later, a placement worker was contacted to talk with the patient. This worker was advised by the QCH worker of the need for further casework with the patient regarding the baby. Adjustment of the patient's hospital bill was made to exclude the baby's expenses. Later, the baby was referred to a placement agency. On last contact with the patient, she was continuing contact with the placement worker.

Evaluation:

The patient's first plan was to live with her married sister, to return to work, and to have the baby placed for adoption. Her plans remained the same on discharge.

The patient said that she was influenced in her planning by the support given her by members of her family, especially her married sister who was sympathetic and devoted to her. The worker also directed the patient's planning to arrangements for the baby.

Areas in which the patient requested help were as follows:

1. Placement of the baby for adoption.
2. Adjustment of the hospital bill.

The patient had her own living arrangements and the worker was unable to give any help in that regard except for the baby.

Arrangements were made with a placement worker to take the baby and to carry on further casework with the patient to insure the future well-being of the baby. The worker also contacted the QCH Accounts Office to adjust the patient's bill to exclude the baby's expenses as requested. Suggestion was also made of a maternity home but the patient would not consider this. The worker collaborated with the placement worker and later referred the baby and patient to that agency. The worker also gave interpretation of the various problems to the patient and her sister, thus giving reassurance and support.

Case 3:

> D., age twenty-five years, was referred by a ward nurse for social review since this was her second illegitimacy by the same man. Her first child was born at a maternity home but died of a heart disease. The general condition of both the patient and her present baby were reported good.
>
> The patient seemed pleasant and friendly but rather nervous. She was thinking about having the baby adopted or placed but she could make no decision as yet. She also planned to work as soon as possible.
>
> The baby's father was many years older than she and had two grown children. He owned a theater and could afford support but he was married. The patient refused any legal action or support as she did not want to break up this man's home. She had only seen him once after the first baby's birth and again became pregnant.
>
> The patient was the oldest of five children and the rest were all boys. She had done clerical and waitress work, and worked until the day before delivery with no pre-natal care.

Her father was an engineer and supported the entire family except the patient and his oldest son. The father reported that he had a large, well-kept home.

No one in the family knew of the patient's pregnancy. Her friends thought that she was in the hospital for an operation. She told her father when she began to have labor pains and he fainted at the time. Her mother was presently at QCH with pneumonia but knew of the pregnancy from her husband. The patient's father was intent on finding the baby's father and told the worker that the patient was stubborn and unreasonable.

The worker suggested resources of temporary placement and adoption to the patient. Later, on request, arrangements were made for temporary placement, until the patient could decide on whether to take the baby home or have it adopted. The patient was concerned about the selection of a home for the baby and was told she could discuss this with the placement worker as well as other problems. She also felt that placement agencies only wanted to take babies away from their mothers. The worker assured her that the plans would be her own, but plans for the baby should be important. The baby was later referred to that agency.

On last contact with the patient, she was doing housekeeping for the family as her mother had died of a heart attack. She could not return to work as planned and was still undecided about the baby but was discussing the situation further with the placement worker.

Evaluation:

The patient was at first undecided about plans for herself and the baby. She was going to work, however. Later, she returned home to do housekeeping for the family. The baby was temporarily placed but the patient was still undecided about its future.

The patient said that she was influenced in her planning by the interest shown by the family in wanting her home. The worker, however, influenced her planning for the baby by direct-

ing the patient's attention to the baby's needs. The worker was unable to help the patient with her own planning for living arrangements but was able to plan for the baby.

The area in which help was requested by the patient was as follows:

1. Referral of the baby for temporary placement.

Resources of temporary placement and adoption were suggested to the patient. The QCH worker also collaborated with the placement worker, interpreting the situation. Since the patient was worried about the selection of a home for the baby the patient was told she could discuss this and other problems with the placement worker - thus she was given assurance and a strengthening support. Since the baby was referred to the placement agency, the worker insured future planning for the child by referring the patient to that agency for further counseling. Contact was also made with the patient's father as to his reactions in the situation.

Case 4:

> A hospital doctor referred E., thirty years of age, to medical social service for help in placement of her baby born two days previously. The baby was in good condition but the patient was to be hospitalized from ten to fourteen days for post-partum care.
>
> The patient was friendly and talked freely but she seemed uncertain and under tension. She wanted the baby placed and later adopted, as she was anxious to do what was best for the child. She had no place to take the baby and felt that placement was best. She did not mention what plans she had for herself.

The baby's father was a thirty-two year old man whom she had known for seven years. He was a clerk and earned thirty-five dollars a week. She had been intimate with him intermittently and told him of the pregnancy. He refused to marry her and preferred to go to court. An attorney was working on the situation.

The patient's mother lived in Boston and a married sister out of state. The patient spoke of her unhappy childhood and how she went to work after completing grammar school. She had held many jobs but only had forty dollars in savings. Her mother was going to pay her hospital bill.

The patient was living in a room in Boston but left because of the pregnancy. She lived with her married sister for a while and her sister was sympathetic and devoted to her. Later, she stayed at her mother's room. Her father had deserted the family twelve years ago. Her mother was tense and upset but helpful. Her mother felt that the baby should be adopted.

The worker pointed out social implications of the situation and told of resources such as child placing agencies. Later, on the patient's request, it was arranged for a placement worker to talk with the patient. The patient was concerned about baptism of the baby and the worker found out from a priest that this could be arranged when the baby left the hospital. When the patient was anxious to leave, the worker interpreted the need for her to stay longer. Contact was also made with the mother to interpret to her the social implications of the situation.

On discharge, the patient was going to live with a friend whom she wished to take the baby. This was found to be not possible and referral of the child to the placement agency was made on patient's request. The patient was also referred to that agency for further casework.

Evaluation:

The patient's first plans were to place the baby for adoption. Her own plans were not decided. On discharge, the patient went to live with a friend and placed the baby for adoption.

The patient said that she was influenced in her plans for the baby by the fact that she had no place to take the child. In this respect, the patient was influenced in her planning by the worker.

Areas in which help was requested by the patient were as follows:

1. Placement of the baby for adoption.
2. Contact with priest regarding baptism of the baby.

The worker was not able to help the patient with plans for her own living arrangements as she was going to live with a friend. The worker collaborated with the placement worker in arranging for placement of the baby. It was also found that the baby could be baptized after leaving the hospital. In contacts with the patient and her mother, the worker gave support and reassurance by interpretation of the social implications of the situation. The patient was also assured of resources available for the baby and she was referred to the placement agency with the baby for further casework to insure the baby of planning for its well-being.

Case 5:

> The mother of M., age twenty years, contacted medical social service two days prior to the patient's admission, requesting medical care for the patient which the family could not afford. On admission, the situation was again referred to social service by a nurse for social review, as the patient gave birth to a child and was unmarried. Both the patient's and the baby's general health were considered good.

The patient looked very comfortable. Her first reaction was that the baby would please the baby's father. She had planned to be married the previous weekend but she was admitted. She mentioned no plans for herself or the baby at this time but was hoping to see the baby's father. He did not know of her admission but would hear about it through friends. She wanted to marry this man.

The patient requested that the worker contact her mother and a girl friend to visit her. Her mother told the worker that she was not feeling well enough to visit but gave the worker information on the patient on a home visit by the worker. The patient had known the alleged father for about a year. He reportedly drank and had a record. The patient had two older siblings, a sister and a brother. The sister was a high school graduate, had a good job and good friends. The patient was careless with money, could not hold a job long, and did not finish high school. She had been a difficult, stubborn child and also resented contributing her earnings to the family.

The mother was a semi-invalid. Her husband was unemployed. Her son was not working but the mother would not have him contribute to the family. The brother reportedly supervised the patient. The mother said that she had been brought up an orphan and felt that the patient should marry the baby's father to give the child a name. The family disliked this man.

The mother felt that the patient should suffer for what she did. She could not help the patient as the other children threatened to leave home, if the patient returned. She would like to take the baby but would not like publicity because of the patient. The mother was insistent that the patient not give up the baby because the mother knew what it was to be an orphan. She gave the worker some money and other articles for the patient.

When the patient heard of the family's reaction, she wanted to live out with the baby and return to work to support the child. Suggestions of temporary placement and maternity homes were made. The patient was deferring any plans until the baby's father visited her. When this man failed to visit, she decided to go to a maternity home as arranged by the worker.

At time of discharge, a layette was arranged through FSS and the patient's clothes were obtained from home on her request. At time of referral, the patient was disappointed that the baby's father had not seen her. After discharge, the patient's

mother became seriously ill and the patient was asked to visit her at QCH. The worker arranged this in collaboration with the maternity home worker. Her visit to QCH was the worker's last contact with the patient. She remained indifferent and bitter toward her mother.

The worker later collaborated with the home worker regarding jobs and vocational guidance for the patient. A job was found available near Quincy. Prior to discharge from the maternity home, the baby's father was contacted by the patient but he was not interested in marriage. She took no legal action. After discharge, she was working but going with the baby's father again as well as another man. She was later convicted on a morals charge and sent away for a year. The baby had been to numerous foster homes and later was taken by the patient's mother, although this was not considered good because of the mother's physical condition.

Evaluation:

At first the patient had no plans for herself or the baby but was deferring plans until she saw the baby's father. She later decided to go to a maternity home with the baby when this man did not visit her.

The patient said that her plans on discharge were influenced by her disappointment in that the baby's father had not visited her as she wanted marriage.

Areas in which help was requested were as follows:

1. Contact with the patient's mother and a girl friend.
2. Layette for the baby and clothing from home for the patient.
3. Referral of patient and baby to a maternity home.
4. A maternity home worker requested help in arranging the patient's hospital visit to see her mother and help for the patient in job possibilities.

The worker arranged a visit by a girl friend to see the

patient, and when the mother could not come, the worker made a home visit to the mother. The worker suggested resources of temporary placement and maternity homes to the patient and later made referral of patient and baby to a maternity home on the patient's request. The worker also collaborated with a maternity home worker in arranging the patient's visit to her mother at QCH and suggested resources of job possibilities and vocational guidance for the patient.

Prior to the patient's discharge from QCH, a layette was arranged for the baby through FSS and the patient's clothing was obtained from the patient's home by the worker when other attempts failed. The worker also gave support and reassurance throughout contact with the patient and her mother by interpretation of the social implications of the problems. Finally, in referring the patient to a maternity home, the worker was insuring further planning for the baby by recommending further counseling for the patient at that agency.

1

Summary of Case Findings

Group 1:

In four cases, referral of the patient to medical social service had been made by a QCH nurse. In one case, the patient was referred by a maternity home; one, by a QCH doctor; and one, by the patient's home doctor.

First plans of these patients were as follows. Four patients would return home with their babies; one would board the baby with a married sister; one would place the baby temporarily with the putative father's brother; and one would live with the baby at the home of the putative father's sister. Three patients mentioned that they would return to work.

Plans on discharge of these patients were as follows. Four patients were returning home with their babies; one was going to live with the baby at the home of the putative father's sister; one was placing the baby with the putative father's brother and would room out; and one would live with the baby at a married sister's home. Three patients were returning to work.

In no case was the worker able to plan living quarters for either the patient or the baby. In all but one case the plans of the patient on discharge were the same as originally planned.

The patients' plans regarding the baby's father were as follows. Three patients were taking legal action; three were planning marriage; and one mentioned that her mother would look for this man to discuss the situation.

The main factors which the patient said influenced her on planning were as follows. Five patients were influenced in their plans by the support given by members of their family. Two patients were making plans because of the support given by the putative father in marriage planning.

Areas in which help was requested by the patient were as follows. There were four requests for medical assistance; three each, for material and financial help; two, for counseling on baby care; one, for vocational guidance for the baby's father; and one, for the worker's contact with this man.

Areas in which help was given were as follows. In two cases, material assistance was arranged by QCH medical social service. There were three cases each, in which referrals were made for medical and financial help; two, for material assistance; one, for vocational guidance; and one, for counseling.

In all but one case, the worker contacted members of the patient's family but in only one case was contact made with the putative father. In all but two cases some community agency would do followup work with the patient through arrangements made by the worker.

In all cases the worker collaborated with other agencies; gave medical social interpretation of the various situations; suggested community resources; and gave support and reassurance.

Group 2:

In two cases, the patient had been referred to medical social service by a QCH nurse; one, by the patient's home doctor; one, by a QCH doctor; and one, in which the patient's mother and a QCH nurse made referrals at different times.

First plans of these patients were as follows. Three patients

were undecided about plans for themselves; one would return home; and one would live with a married sister. Three patients would return to work. Two patients would place their children for adoption; two were undecided; and one would have her married sister care for the baby at home.

Plans of the patients on discharge were as follows. One patient was going to live with a married sister; one was going home to do housekeeping for the family; one was going to live with a friend; one was going to a maternity home; and one mentioned no living arrangements although she was to be married. Two patients were returning to work. Two patients placed their babies for adoption; two placed their babies temporarily; and one took her baby to a maternity home.

In only one case was the worker able to make living arrangements for the patient but in all five cases the worker made living arrangements for the baby. In only one case was the patient's plans on discharge the same as originally planned.

The patients' plans regarding the baby's father were as follows. Two patients planned legal action; two intended no action; and one planned marriage.

The main factors which the patient said influenced her planning on discharge were as follows. In two cases support given by members of the patient's family influenced her planning; in one, the patient had no personal resources for the baby; in one,

the patient was supported by the putative father in marriage plans and in one, the patient was planning because of disappointment in marriage plans.

Areas in which help was requested by the patient were as follows. There were two requests each for material assistance, temporary placement, and placement for adoption. One request each was made for financial assistance, vocational guidance, counseling, contact with a girl friend for the patient, contact with a priest regarding baptism for the baby, and maternity care for patient and baby.

Areas in which help was given were as follows. In one case, material assistance was arranged through QCH medical social service. In all five cases, the patient was referred to that agency taking the baby for further counseling in plans for the baby. In two cases each referral was made for temporary placement, placement for adoption, and financial assistance. One referral was made for maternity home care for patient and baby and one referral for material assistance.

In all cases the worker contacted some member of the patient's family giving interpretation of the situation, on patient's request. In one case a girl friend was contacted to visit the patient and in one case a priest was contacted as to baptism for the baby. The worker also spoke to one putative father giving him various resources for assistance and advising him to

keep in touch with a placement agency which was caring for the baby.

In all cases the worker collaborated with other agencies; gave medical social interpretation; suggested community resources; and gave support and reassurance.

V

CONCLUSIONS OF THE STUDY

In comparing the two groups described in the previous chapter, the main difference seemed to be the way in which the worker helped plan for the patient and her baby. For those patients who took their babies, the worker in most cases arranged followup with the patient through some community agency to help insure planning for the baby's medical social needs. For those patients who requested help with living arrangements for their babies, the patient was referred in all cases to the agency working with the baby for further counseling and planning.

In the first group, all patients had living quarters for their babies and themselves. The worker was unable to help in this respect as evidenced by the fact that most plans on discharge in this group remained the same as originally planned.

In the second group, all patients requested living quarters for their babies and in only one case for themselves. The worker was able to help in this respect as evidenced by the fact that most plans on discharge were somewhat different than originally planned. This change was due in part to the worker's planning with some of these patients who were at first undecided, and partly due to other factors in the situation.

In both groups, the factors mentioned most frequently by

the patients as influencing their planning were the support by their family and the putative father. In most cases the worker contacted members of the patient's family, bringing them into the planning whenever possible. However, the baby's father could only be contacted in two cases but valuable assistance was given these men by the worker, in helping with their plans and in exploring their feelings about the situation.

The significance of the patients' plans regarding the baby's father was that in most cases the patient was taking some course of action to insure the baby's financial support whether it be through marriage or through some kind of legal action.

Referral in most cases was made by QCH doctors and nurses. This was an indication of the recognition by these hospital personnel of the dynamic part played by medical service in problems of these patients. It also pointed out the collaboration between the members of the hospital team which is an accepted function of the hospital setting.

In all cases, common trends of casework assistance emerged but the primary concern of the worker seemed to be in planning for the baby because of the limited hospitalization period. This was accomplished through reassurance and a strengthening support given the patient so that she would understand and realistically accept the responsibility and needs of the baby as well as her own. Referral for further assistance in planning was the final step of the worker, thereby insuring that the patient would have ample

opportunity to make adequate plans for the baby.

From this study, the writer noticed several apparent needs which could be more appropriately carried out through other agencies due to the limited contact of the hospital worker with the patient. Further casework seemed necessary around the the fears of the patient and members of her family in regard to publicity and community rejection. Some of the patients also feared that placement agencies would take their babies from them. Education of the patient as well as the community as to the purpose of these agencies would appear to be valuable.

Home visits would seem in order in many cases to appraise most effectively the living accommodations of the patients and their babies. The family itself might have problems which might further affect the situation.

Depending on the situation, contacts might be made with more of the baby's fathers to determine their feelings. The attitudes of the patients toward these men would also seem to need further investigation.

From the cases studied, most patients had no pre-natal care prior to admission because of their fears of the pregnancy being discovered by their families or others in the community. The community would seem to need more instruction in realizing the need of referral of these patients for pre-natal care to safeguard the health of the baby as well as that of the patient.

Moreover, many of these patients during this period might profit emotionally so that following delivery they might be more definite in plans for the baby as well as for themselves.

This study also indicated that of those patients who took their babies, some were referred to the Visiting Nurse Association for followup whereas others were referred to other community agencies depending on the need.

It is suggested that a public child welfare unit might take full responsibility for followup with these patients and their babies. In some cases of this group, it seemed apparent that between the time these patients left the hospital and other plans were made for themselves and the babies, a gap in services existed. During this time followup by such a child welfare agency might be very beneficial. This agency could then interpret social service resources and needs to the hospital, private doctors, and others of the public in an effort to work out a community plan.

Approved:
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VI

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VII

APPENDIX

Schedule

PATIENT

Name

1. Circumstances of referral
2. Immediate situation (as seen by worker)
    1. Patient's first reaction
    2. Patient's plans for herself and baby
3. Circumstances of the pregnancy
4. Attitudes of patient and baby's father to the pregnancy
5. Attitudes of patient's family
    1. Family background
    2. Previous attitudes to patient
    3. Present attitudes to patient and baby
    4. Their preferred plan
6. Activity of the worker
    1. Interpretation of medical social problems
    2. Suggestion of community resources
    3. Collaboration with other agencies
    4. Material assistance
    5. Contacts with family, baby's father, and others
    6. Support and reassurance
    7. Referral

7. Outcome of casework

    1. Plans for patient

    2. Plans for baby

8. Termination of case

CASE SUMMARIES AND EVALUATIONS

COPY OF SOCIAL SERVICE "BLUE" SHEET

Name:	Sex	Age	Race	Marital Status	Nationality
Address:				Birth date	Birthplace
				In U.S. ?	Citizen
				In Quincy ?	Settlement
				Religion	Church
				Diagnosis	

Relatives:

Interested Individuals	Address	Relationship

O.P.D. No.

Social Service Index: House No. Admitted Discharged